No. 97-1489

In The

Supreme Court of the United States

October Term, 1997

YOUR HOME VISITING NURSE SERVICES, INC.,

Petitioner,

v.

SECRETARY OF HHS,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

REPLY BRIEF FOR THE PETITIONER

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PETITIONER'S REPLY TO RESPONDENT'S BRIEF

This reply brief is submitted in accordance with United States Supreme Court Rule 15.6 which allows petitioner to address new arguments first addressed in respondent's brief. Accordingly, there are five matters which petitioner will address herein: mandamus jurisdiction, statistics regarding the pending cases at the Provider Reimbursement Review Board, the *Regions Hosp. v. Shalala*, 118 S. Ct. 909 (1998) decision, due process arguments and the right to attorneys fees under the Equal Access to Justice.

(a) Mandamus Jurisdiction, 28 U.S.C. 1361

The Respondent's brief at page 13 noted that this Court has declined to decide whether Section 405(h) precludes federal mandamus jurisdiction under 28 U.S.C. 1361 but also recognized that the Court has concluded that mandamus jurisdiction is appropriate under the Medicare program if the defendant owes the plaintiff a clear non-discretionary duty. The respondent asserts there is a discretionary decision at issue since the Secretary's reopening regulation vests the intermediary with the exclusive jurisdiction to decide whether to reopen its own prior determination. 42 C.F.R. 405.1885(c). The petitioner however relies upon the non-discretionary duty referenced in the regulation 42 C.F.R. 413.102(b)(2)(i) which requires that owners compensation be " . . . such an amount as would ordinarily be paid for comparable services by comparable institutions." The refusal to reopen the 1989 cost report to correct this error is a violation of a duty which is NOT discretionary. In other

words, the intermediary does not have the discretion to violate this regulation by choosing not to pay the owners of the petitioner/home health agency an amount as would ordinarily be paid for comparable services by comparable institutions, and yet, this is exactly what the intermediary did. The regulation requires that payment to owners be comparable to payment made for comparable services by comparable institutions. Comparing a single home health agency's Administrator's salary to that of a chain operation is not in accordance with this non-discretionary regulation requirement. Therefore, mandamus jurisdiction would be appropriate to provide federal court with authority to order the intermediary to pay the owners in accordance with the regulation because the respondent owes the petitioner a clear non-discretionary duty in this regard.

(b) Statistics on pending cases at PRRB

The respondent points out administrative burden which the reviewability of denials of requests to reopen presents as an important and recurring issue for the "already overburdened" Medicare program by citing statistics obtained from the Health Care Financing Administration in the Department of Health and Human Services which allegedly demonstrate PRRB has a backlog of 10,000 cases, that the Secretary estimates that the PRRB has approximately 20 appeals pending, at any given time, on reopening denials by providers located in the Ninth Circuit. (See Respondent's brief at page 16, notes 8 and 9.) While conscious of the administrative burden which

appeal rights create, the petitioner must nevertheless persist in its pursuit of the right to appeal erroneous determinations made by the intermediary. This is true even when the wrongdoing of the intermediary is not discovered until after the initial 180 day deadline to appeal the NPR determination. The three-year time period within which to request a reopening should still allow the provider who discovers the intermediary acted inappropriately to take action against the intermediary. In support of this contention the petitioner would point out that the intermediary is an insurance company which could be guilty of wrongful action. Cases against the insurance companies for wrongful conduct related to Medicare program payments to the insurance companies have been reported. Blue Shield of California was ordered to pay $1.5 million following a guilty plea on charges that it conspired to obstruct audits conducted over a six-year period in connection with its Medicare Part B contract with HCFA according to a May 1, 1996, Department of Justice press release. (Reported in the Commerce Clearing House Medicare and Medicaid Guide Number 905, May 9, 1996.) Blue Cross and Blue Shield of Florida, Inc., the Medicare Part B carrier for Florida, agreed to pay the federal government $10 million pursuant to a settlement agreement executed by the parties on August 3, 1993. *U.S. ex rel. Burr v. Blue Cross and Blue Shield of Florida, Inc.*, U.S. District Court for the Middle District of Florida, No. 91-134-Civ-J-16, Aug. 4, 1993. (Reported in the Commerce Clearing House Medicare and Medicaid Guide Number 761, August 18, 1993, and at Paragraph 41,578.) Blue Cross and Blue Shield of Michigan has agreed to pay the government $27.6 million to

settle allegations that it defrauded the government while acting as the fiscal intermediary in the state of Michigan. *U.S. v. Blue Cross/Blue Shield of Michigan*, U.S.D.C. (Maryland), No. L93-1794, Jan. 10, 1995, settlement agreement executed by the parties. (Reported in the Commerce Clearing House Medicare and Medicaid Guide Number 839, February 2, 1995, and at Paragraph 43,019.) While the administrative burden and a backlog of cases is always a consideration, the right to seek redress for wrongful conduct should take precedence in this situation.

(c) *Regions Hosp. v. Shalala*, 118 S. Ct. 909 (1998)

The respondent states that the intermediary analyzes the cost report, audits if necessary, and then issues the written notice of the amount of Medicare program reimbursement to the provider, citing the recent decision of *Regions Hosp. v. Shalala*, 118 S. Ct. 909 (1998). (Respondent's brief at pages 2-3.) It is interesting to note that this case stands for the proposition that additional reopenings beyond the normal three year time frame are acceptable in order to perpetuate the Legislature's overriding purpose in the Medicare scheme: reasonable (not excessive or unwarranted) cost reimbursement. *Id.* at page 905. Therefore, the Secretary's position in Regions Hospital creates more administrative burden by allowing reopening and reaudit beyond the three year time frame because this allows the Secretary to recoup reimbursement from providers which may have received too much Medicare money. However, when the provider-petitioner herein seeks reopening within the three year time period because it received too little Medicare reimbursement, the

Secretary fears the administrative burden such corrections might produce. The Secretary is inconsistent. The apparent goal is to recover Medicare reimbursement from providers as opposed to the more appropriate goal of paying the correct amount of reimbursement to providers.

(d) Due Process, United States Constitution, Amendment V

The respondent asserts that it does not believe the due process contentions should be considered by the Court citing *Youakim v. Miller*, 425 U.S. 231, 234 (1976). (Respondent's brief at page 16) However, the Court recognized that while it ordinarily does not decide questions not raised or resolved in the lower court the rule is not inflexible. *Id.* at page 234. In *Boynton v. Virginia*, 364 U.S. 454, 457 (1960) the Court found persuasive reasons why the case should be decided on the Interstate Commerce Act although the petition for certiorari presented only two questions, one of which included the Due Process clause of the Fourteenth Amendment. The Court reasoned that discrimination because of color was the core of the two broad constitutional questions presented, just as it is the core of the Interstate Commerce Act. Under those circumstances, the Court found it appropriate not to reach the constitutional questions but to proceed at once to the statutory issue. While the petitioner believes the Court can and will make its decision in the present case based upon the statutory authorities presented, if that cannot be done then the core argument, which is the due process considerations of the complete deprivation of an

appeal process for a denial of a reopening request, should be considered by the Court in deciding this case.

(e) Equal Access to Justice Act, 5 U.S.C. 504 and 28 U.S.C. 2412

The respondent asserts that there is no basis for the petitioner's request for a review of whether the Secretary's position in this case if "substantially justified" under the Equal Access to Justice Act, 5 U.S.C. 504 and 28 U.S.C. 2412 because the petitioner has not filed a fee application in this case and therefore the lower courts had no occasion to address this question. Changes in reimbursement for home health agencies which are occurring during this cost reporting period now make the question of an award of attorney's fees appropriate at this time. Therefore, the petitioner asserts the Court should consider the question of whether or not the Secretary's position can be substantially justified in regard to the attorney's fees related to this proceeding.

CONCLUSION

The petition for a writ of certiorari should be granted and the questions presented for review as stated in the petition should be addressed.

Respectfully submitted,

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